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ORIGINAL ARTICLE

"It Makes you Want to Go Out and Change the World": Shifts in Victim Advocates' Perspectives Following the Intimate Partner Homicide of a Client in the United States

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Abstract

Purpose Intimate partner violence (IPV) victim advocates are exposed daily to the traumas of their clients, including the potential exposure to an intimate partner homicide (IPH). While research has examined the effects of daily secondary exposure to IPV on victim advocates, little is known about the specific effect of IPH. This study examined how the IPH of a client affected advocates' perception of and approach to their work.

Methods Nine advocates were recruited from the northeastern U.S. and interviewed about their experience of the IPH of a client. Advocate interviews were analyzed using The Listening Guide Analysis which systematically isolates and listens to the different, and often contradictory, voices that a participant uses.

Results Exposure to IPH changed participants' perception of their role, how they defined client, and how they interacted with future clients. At a macro-level, the IPH of a client motivated advocates to advance changes in agency protocol, multisector responses, and state policy based on what they had learned from the IPH. Opportunities to translate shifts in their worldview into tangible changes to protocol and policy were critical to advocate adjustment after the IPH.

Conclusions In order to support advocates after IPH, organizations should acknowledge the potentially transformative effect of IPH and create opportunities for meaning making to assist in advocate adjustment. It is imperative for advocacy organizations to support their employees to prevent advocate burnout and the loss of experienced staff, and to continue to provide effective services to vulnerable members of their communities after IPH.

Keywords Intimate partner violence · Intimate partner homicide · Vicarious traumatization · Vicarious resilience · Listening guide analysis

Victim advocates, the term for the community-based frontline staff that work with victims of intimate partner violence (IPV), experience secondary exposure to trauma through the empathetic engagement with clients (Pack, 2014; Wasco & Campbell, 2002). This exposure can result in changes to how advocates think about their world and their work (McCann & Pearlman, 1990). These changes can disrupt healthy functioning, known as vicarious traumatization, and can have a positive effect on workers, known as vicarious resilience. While past research has examined the effect of daily secondary exposure to IPV on victim advocates, this is, to the author's knowledge, the first study about the specific effect of the loss of a client to intimate partner homicide (IPH) (See Author et al., 2020 for additional findings). Given IPH's sudden, final, and violent nature, it is possible that its effects differ from that of IPV more broadly and may require targeted organizational responses to prevent vicarious traumatization and promote vicarious resilience. Agencies must proactively respond to vicarious trauma exposure in order to prevent turnover, ensure a healthy workforce, and prevent negatively impacting future clients through inappropriate service provision (Cummings et al., 2021; Maslach et al., 2001; Molnar et al.,. 2017; Tham 2006).

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IPV Victim Advocates and IPH Exposure

IPV victim service agencies assist over 70,000 people in the United States every day (National Network to End Domestic Violence, 2022). One of their primary roles is to advocate within systems, like civil courts, on behalf of victims to ensure adequate and appropriate care (Ullman, 2010; Wasco & Campbell, 2002). As such, advocates have the potential to affect both an individual's life and improve the outcomes of all victims in a community by advocating for system change. Advocates additionally play a critical role in IPH prevention by providing crisis intervention, emergency housing services, and multisector interventions with law enforcement and other providers. Approximately 13% of all homicides in the United States are intimate partner related (Kivisto et al., 2019). While it is unknown how many victims worked with advocates prior to their death, advocates are at risk of IPH exposure through their work. When a clients' healing is disrupted, as is the case with IPH, it could lead to a "crisis in meaning" (Pack, 2014, p. 22) with which advocates must reconcile in order to continue to provide safe and adequate services to future clients. Given IPH's shocking finality, it is important to understand how it may uniquely affect advocates in order to promote vicarious resilience and prevent vicarious traumatization.

Vicarious Traumatization and Vicarious Resilience

When advocates empathetically engage with their clients' traumas, it can affect the way they see the world which can lead to behavioral changes (McCann & Pearlman, 1990). Vicarious traumatization refers to the maladaptive changes for advocates as they integrate the trauma into their cognitive schema (McCann & Pearlman, 1990), whereas vicarious resilience refers to the supportive changes resulting from exposure (Engstrom et al., 2008; Frey et al., 2017; Pack, 2014). When one is repeatedly exposed to trauma, or is shocked by an acute event, it can change how one understands their world; they may believe people to be untrustworthy, become hypervigilant, or feel isolated from their community (Barrington & Shakespeare-Finch, 2013; McCann & Pearlman, 1990). Studies suggest that when the event to which one is exposed is discrepant with prior experiences, it can challenge one's conceptual framing of the world and their work, leading to distress (Park, 2010). A study of social workers who lost a clicent to suicide found that when it was not anticipated, the shock amplified the impacts leading to increased distress (Ting et al., 2006). Studies on the daily exposure to IPV by advocates indicate that they may feel less confident; that the world is unsafe; powerless and yet responsible for client safety; and stigmatized due to their work (Illifee, 2000; Wasco & Campbell 2002). Advocates may even experience intrusive memories such as nightmares or flashbacks (McCann & Pearlman, 1990). If not adequately prevented or addressed, vicarious traumatization's changes to one's self- and world-concepts can lead to impairment through negative behavioral adaptations in one's work, like victim blaming or domineering behavior with clients, or through avoidant coping strategies, like dissociation and numbing (McCann & Pearlman, 1990). This impairment could eventually result in experienced advocates leaving the field, a loss of practice wisdom, and a diminished quality of victim services provision (Cummings et al., 2021; Maslach et al., 2001; Molnar et al.,. 2017; Tham 2006).

At the same time, secondary exposure to trauma can also generate or reinforce positive beliefs about one's self, work, and world (Cohen & Collens, 2013). Studies of vicarious resilience among advocates and other practitioners who work with traumatized populations have found that the work gives practitioners a sense of purpose, feelings of gratitude for their clients' trust, inspiration from clients' grit, and a sense of fulfillment (Engstrom et al., 2008; Frey et al., 2017; Pack, 2014). Generally, vicarious resilience is conceptualized as requiring exposure to clients' resiliency (Engstrom et al., 2008; Frey et al., 2017), and it remains unclear if advocates can experience vicarious resilience in the wake of IPH. In previous work with other social workers that have experienced the fatality of a client, studies report workers "finding new purpose in their work" (Gustavsson & MacEachron, 2002, p. 912), feeling motivated to continue working, and working to improve service delivery and state policies (Douglas, 2013a; Regehr et al., 2002; Ting et al., 2006).

Critically, past research indicates that organizations can prevent vicarious traumatization and foster vicarious resilience through interventions with staff (Cohen & Collens, 2013; Molnar et al., 2017). In fact, in a study of what factors influence child welfare workers to consider leaving the field, including direct exposure to threats and violence, the only factor to significantly decrease one's intention to leave was their perception that the agency supported and was invested in the staff (Tham, 2006). This suggests that changes to agency policy, procedure, and climate can influence workforce sustainability. In order to prevent worker turnover and the potential weakening of services to IPV victims, it is imperative to understand how exposure to critical incidents, like IPH, may affect advocates and how to best support them in its aftermath.

Current Study

The research presented here is part of a larger study that examined how the IPH of a client and the organizational

responses to the advocate after IPH affected advocates' experiences of vicarious traumatization and resilience, particularly with regards to changes in how advocates thought about their work and any related behavioral changes (see also: Author et al., 2020). The study was conducted in 2016, prior to the COVID-19 pandemic, with advocates from a New England state. This paper responds to the following research question: How does the IPH of a client affect advocates' perception of and approach to their work? If advocates are unable to perform at full capacity, the effectiveness of the agency's prevention and intervention programs could diminish, potentially negatively impacting IPV victims (Cummings et al., 2021; Regehr et al., 2002).

Methods

Participant Recruitment

I recruited advocates from the state coalition's listserv of community-based IPV victim advocacy agencies to participate in semi-structured interviews about their experience of an IPH of a client. Advocates were eligible for study participation if they were adults, spoke English, were currently working as staff advocates, and had experienced the IPH of someone whom they perceived to be a client. Based on participants' definitions of "client," a client ranged from individuals with whom they had prolonged relationships through court advocacy work or shelter stays to individuals with whom they had not had direct contact but who had lived in their service area. The majority spoke of individuals with whom they had direct contact (8/9), while six participants also talked about individuals with whom they had not had direct contact. In order to control macrolevel factors in agency response, such as state funding and IPV prevention policies, I recruited advocates from the same state. After this initial sampling stage, I used snowball sampling by asking participants to share my information with colleagues. Nine advocates were recruited, an adequate sample size for the analytic approach used in this study as a multidimensional analytic approach can lead to detailed, rich findings with fewer texts (Josselson & Lieblich, 2002). The sample represented 8% of the total state advocate population from 50% of the state agencies.

Data Collection

I interviewed advocates for 45–90 min using a semi-structured interview guide about their experience of client IPH, with questions like "Can you tell me a story about your experience when a client was murdered?," and "How do you think experiencing a homicide has affected you?" After transcription and the redaction of identifying information, I sent the transcripts to participants for their review and further redaction. Participant review of their transcript is a trauma-informed practice that enables control over their own narrative (Iliffe & Steed, 2000). Participant characteristics and their chosen pseudonyms are described in Table 1. The data collection and analysis plan were approved by the Boston University Institutional Review Board in 2016.

Data Analysis

This study operated from a constructivist self-development framework that acknowledges that each individual has unique responses to traumatic exposure that is dependent on their lived experiences, personality, and cognitive understanding of their world (McCann & Pearlman, 1990).Therefore, I employed Listening Guide Analysis (LGA), a unique analytic approach, which allows the researcher to "listen" to each individual's story and the multiplicity of their experiences before comparing across cases (Gilligan et al., 2003). As Koelsch (2015) notes, LGA permits the researcher and their audience to "focus on each participant's sense of her own position and choice rather than the potentially salacious details of her story," (p. 103), making it an ideal approach to

Table 1 Participant information

Chosen Pseudonym	Current Role	Tenure (years)	# IPHs discussed	IPH in first 2 years or in personal history	Had direct contact with ≥ 1 victim
Elizabeth	Legal services	≥ 10	≥ 5	Unknown	Yes
Gloria	Legal services	≥ 20	3	Unknown	Yes
Guardians	Primary prevention	≥ 15	2	Yes	Yes
Hermione	Child welfare	≥ 15	2	Yes	Yes
Hillary	Supervisor: Legal services	≥ 20	3	Yes	Yes
Isabella	Administrator	≥ 10	1	Yes	Yes
Marisa	Supervisor: Residential services	≥ 20	1	Yes	Yes
Porkbean	Legal services	≥ 5	2	Yes	Yes
Stella	Residential services	≤ 5	1	Yes	No

analyze traumatic topics. LGA outlines four analytic steps, or listenings, of each interview: listening for plot, listening for self, listening for contrapuntal voices, and composing an analysis (Gilligan et al., 2003). I completed these four steps in order for each participant before moving on to cross-case analysis, with memoing at each step.

In the first step, I listened for what story the advocates were telling about their experience of IPH and generated a memo summarizing their story and noting any reactions I had to it (Gilligan et al., 2003). The next step analyzed the voice of self by isolating every I-statement and adjacent predicate or words (e.g., "I have received" [Elizabeth]) in the narrative and then put them chronologically into verses known as "I-poems" (Gilligan et al., 2003). I-poems are used to allow the participant to speak for themselves before the researcher speaks about them (Brown & Gilligan, 1993, p. 27–28). In the third step, I isolated the contrapuntal voices, or points of view, from which the advocate spoke that addressed the research question (Gilligan, 2015). The contrapuntal voices are the same for each case (Gilligan, 2015). Throughout the interviewing and transcription process, I listened to the different ways advocates described the effects of losing a client to IPH. I identified three contrapuntal voices: trauma, resilience, and the lost I. These voices were refined in a collaborative qualitative workgroup of then doctoral students that provided feedback on one another's individual qualitative studies. The voice of trauma was when an advocate spoke of distressing changes to how they viewed their work or their behavior due to IPH. When advocates spoke from the voice of resilience, they indicated growth, gratitude, or pride after the IPH. I noticed that advocates often answered questions about their experience in the plural first (we), second (you), or third person (as an advocate). In order to understand why advocates stopped speaking in the first person, these statements were isolated as a single contrapuntal voice (the voice of the lost I). In the fourth step, I wrote summaries of each listening, analyzed where the voices interacted (e.g., where the voices of self, from step 2 and resilience, from step 3, overlapped), and identified major themes of each person's interview (Gilligan, 2015; Gilligan et al., 2003). After analysis was complete for each participant, I conducted cross-case analyses comparing the voices, how they interacted, and case themes thereby "illuminating similarities in themes" (Gilligan et al., 2003, p. 169) and identifying differences across cases. The final themes about how IPH exposure affected advocates' perspective of and approach to their work are reported below. Analyses were conducted in NVivo 12.

Rigor and Trustworthiness

I used several methods to decrease potential bias and increase the study's rigor and trustworthiness. I developed the interview guide from key informant interviews and then revised it based on additional interviews about the protocol. Based on my professional experience as an IPV victim advocate and researcher, I approached the research from the standpoint that IPH may affect advocates differently than IPV due to its finality. To counteract this potential bias, I used three main strategies (Maxwell, 2013). First, I used peer feedback from a collaborative qualitative workgroup throughout the process to refine my study design, analysis plan, and analytic interpretations (Hays & Singh, 2012). For example, as mentioned above, the peer group gave me feedback on the contrapuntal voices. Second, I asked participants directly if they thought that IPH affected their work differently than IPV (e.g., "If none of your clients had ever been murdered, do you think your experience as an advocate would have been different? If yes how, if not, why?"). This allowed participants to speak for themselves and directly comment on the research topic. Finally, preliminary results were shared with other populations of advocates and advocates from the original study state as means of member checking and assessing ecological validity (Hays & Singh, 2012; Maxwell, 2013).

Findings

Experiencing an IPH affected both how advocates perceived their work and how they approached their work. Interweaving voices of trauma and resilience marked a central pattern across participants: that from these tragedies emerged meaningful, positive changes to themselves and their communities. Notably, seven of the advocates experienced an IPH within the first two years of their advocacy career or prior to their career (Table 1). This early experience made IPH feel "ever present" [Hillary], making it hard for advocates to disentangle the effect of IPH from their work more generally, although all were able to identify some shifts. These changes occurred in two overarching themes. First, their conceptual framing of their worked changed: who they considered a client, advocacy's goal, and the reality of loss. Second, there were changes to how the advocates worked: how they worked themselves, as part of an agency, and as part of a community intervening in IPV.

IPH Changed How Advocates Perceived Their Work

The Victim Became Everyone's Client

IPH affected who advocates considered a client. While most advocates (8/9) described the homicide of a client with whom they had had direct contact, several (6/9) also identified IPH victims as clients with whom they had no direct contact but who lived in their service area. In some cases, the victim had worked with others at the agency, however in several of the cases discussed, the victim had had no contact with the advocate nor the agency. Advocates indicated two mechanisms by which someone became a client after IPH even without contact: job duties and feelings of responsibility. Advocates detailed several job duties after an IPH in their community, like working with law enforcement, following up with families, and dealing with the media. Elizabeth discussed how doing follow-ups with families and attending funerals affected her and her connection to the client: "People would come up and talk about her as a person and how they grew up together… and I felt like at the end of it I knew her, which was extremely sad." Even when advocates had not interacted with the victim, they began to know them through the follow-ups after the IPH. Additionally, several advocates talked about how IPH rippled through communities "like a mushroom cloud of trauma" [Hermione], often resulting in IPV victims or their loved ones accessing services because of a heightened fear of IPH. As Guardians described:

> We had people coming in… so traumatized by what happened. You know, some of these are people that lived right next door to them, you know, 'I wish I would have known and now I'm in this situation.' … It's this ripple effect of fear and anxiety.

Even when an advocate had not worked with the client directly prior to the IPH, the advocate had to complete job tasks related to them, creating a feeling of connection to the client.

The second mechanism by which one became a client was responsibility. While all participants stated that the IPH perpetrator was solely responsible, they questioned their role in the aftermath of the IPH. Hermione's intersecting voices of trauma and self illustrate this questioning of if she could have done more, "I definitely felt/ what did I say/ what, what could I have said/ could I have called." Elizabeth, Gloria, and Stella all discussed IPH cases in which the victim did not have prior contact with anyone at the agency. Elizabeth described thinking "God, that's a big miss" after an IPH; indicating some guilt, wondering if the victim would have lived if they had been connected with the agency. As Stella described:

> I went through the struggles of … 'Was there ever a call that she did make to us on the hotline? Did anyone try to reach out to her?' All those things go through your head of what could have prevented this; 'Is there anything we could have done?'

The data indicated that advocates extended their traditional role of IPV intervention through direct service provision (Ullman, 2010) to IPV prevention with all those living in their communities irrespective of direct contact. This responsibility created a bond between advocate and victim. This broad definition of client meant that advocates discussed IPH's effect in the same manner for clients with whom they had contact as those with whom they had not.

Defining Advocacy as "In the Living"

How advocates defined advocacy and their responsibilities affected their adjustment after IPH. Defining advocacy as supporting the client rather than as preventing violence was as an important buffer against distress for eight advocates. For three advocates, this definition preceded the IPH and served as an important protective factor against distress in its aftermath. As Marisa described, her approach to advocacy was:

> Not only a voice for those who might be finding their voice, but it's supporting and encouraging them to use their own voice, … I look at advocacy as almost in the living, … as an everyday opportunity to have people learn about themselves.

This focus on empowerment helped Marisa after the IPH, and as a supervisor, she encouraged her supervisees to work from this resilient perspective as well. While some advocates came to the work with this buffer, others developed it after the IPH, often through the support of supervisors or more experienced colleagues. Advocates learned to focus on the support they could offer rather than the ultimate outcome of a case. Elizabeth illustrated this mindset when discussing responding to a family after an IPH: "Getting that counselor established, like I couldn't fix the problem. But that counselor would be a really huge piece to their puzzle at some point." By defining advocacy as something other than IPH prevention, the advocates were able to focus on what they could control and evaluated themselves on how they acted in the moment rather than on the case outcome.

IPH Became a Reality

While advocates had understood that they might be exposed to IPH, it was not until a client was killed that it became a reality. Isabella reported: "And then it was 'Oh my god, they really do [die], they really do! It's not a statistic, they do!'" indicating a discrepancy between her prior understanding of IPV and her experience of IPH. Elizabeth's intersecting voices of trauma and self described it as "I just/ I think/ I just didn't believe." Advocates reported that this shift in reality was galvanizing. As Porkbean stated: "it like makes you want to go out and change the world, 'cause the one that you're living in doesn't feel like the old one you used to live in." The new cognitive belief that a client could really die, changed how the advocates not only understood their own work, but ultimately transformed *how* they worked.

IPH Changed How Advocates Approached Their Work

Advocates discussed changes to their own approach to the work, to agency protocol, to multisector collaboration, and to state policy after IPH. Across advocates, these changes were expressed at moments in participant narratives where the voices of trauma and resilience overlapped, indicating that from distress came growth. Importantly, the ability to learn from IPH and improve future victim outcomes helped the advocates integrate the IPH into an empowered cognitive framing of their work and world. As Hillary noted: "Out of homicide has come some really amazing work."

Changes in Individual Approaches to the Work

When advocates shifted their definition of advocacy to concentrating on the factors they could control, it also changed how they worked. Advocates learned to focus on resource referrals, to increase client agency, and to translate the lessons from the IPH to prevention programming. Advocates became more forthright about the risk of IPH with clients when safety planning. These discussions were not the result of a hypervigilant response to the IPH trauma, rather, the advocates seemed to see IPH risk as an important factor for clients to consider during safety planning. As Elizabeth stated: "I want to hear where they're at and I want to tell them everything I know. And I want them to be informed when they're making their decisions and their choices." Advocates additionally talked about the risk factors of IPH that they learned from their experience. They talked about the "back-of-your-mind thing [that] surfaces" [Stella] when a client describes risk factors. When they heard this risk, advocates described being more vocal: "that's the new normal for me now, 'cause I'm more likely to air on the side of caution and say, 'look, I don't want to scare you, let's hope for the best, but we need to plan for the worst'" [Porkbean].

Some advocates also described being more assertive with collaborators, wanting to ensure that other providers took the risk of IPH seriously. As Gloria's interwoven voices of trauma, resilience, and self state "I'm not gonna back off/ I'm not gonna back off/ I'm gonna be like/ I'm not gonna / I'm not gonna back down." This active approach was seen by Gloria as honoring the memory of her lost clients: "I feel like I carry those people/I carry those women." Based on their experiences, the advocates not only changed how they worked, but also transformed how their agency approached IPH.

A More Proactive Agency Approach

Many of the advocates discussed how their agency's response to cases with a high lethality risk changed based on their collective learning from IPH. Many advocates expressed that advocacy's traditional "voluntary service approach" [Stella] was dependent on individuals seeking the services themselves. Gloria discussed that after the IPHs she and colleagues experienced, they developed a more proactive approach for high-risk cases: "Now, if we're really concerned about people, we don't wait for people to call us. We want to make sure that their safety is paramount and that's being tended to." How agencies responded to high-risk cases varied, but several advocates discussed the creation of high-risk teams.

Increased Multisector Collaboration

High-risk teams are multisector teams that deliver coordinated responses to prevent violence in cases with high lethality risk (Jeanne Geiger Crisis Center, 2019). Many of the advocates discussed their own leadership in the creation of these teams in response to the weaknesses in community responses they saw after IPH. Porkbean noted: "[The IPH] was really the genesis for us creating the County High-Risk Team…that's the legacy of this one situation." Advocates who sat on high-risk teams described how the teams have led to better working relationships with other sectors, particularly with law enforcement.

Outside of high-risk teams, advocates discussed how experiencing an IPH led to better multisector collaboration. In a parallel process to the shared trauma experienced by the general community, professionals charged with preventing and responding to IPH were also affected by this shared experience. Gloria noted: "I mean everybody was affected by that because it was a horrible, hideous murder,… so it's something that we shared. We still do share it." These shared experiences motivated communities to reflect on their roles

and to work together to improve multisector responses to IPV. As Hillary emphasized: "I think it's a result of having experienced homicide, …we've all grown and changed; our relationships are stronger." For advocates, IPH underlined the importance of coordinated team responses to prevention, resulting in improved multisector relationships and interventions.

New Legislation and the Fatality Review Panel

When advocates reflected on what they learned from IPH, they often talked about system policies that could have better protected the victims, even though at the time, "we did …what we could do in the moment of serving that person" [Hillary]. Many advocates discussed actual changes in legislation that resulted from IPH. For example, Marisa explained, "You hate to use the phrase of 'well what will it take, someone dying before changes happen?' And literally that's what has had to happen," to describe changes to bail policy. She discussed how after several cases where abusers killed their partners while released on bail, the state changed how courts set bail conditions.

Many of the policy changes discussed came from recommendations from the state's fatality review panel. Fatality review panels are multisector panels that are charged to review IPH in the state and make recommendations to the legislature based on their review (National Domestic Violence Fatality Review Initiative, 2016). Elizabeth described the panel's work as: "we have to make a global recommendation, but they are all based on individual reports." Even advocates who did not sit on the panel viewed it as a central way that the laws were changed to better serve victims. Isabella said: "I think the fatality review panel is wonderful, the recommendations that come from that panel do save lives." The panel's recommendations helped the advocates feel like their clients were seen and that their loss contributed to making the community safer. The panel recommendations and changes in legislation were central to advocate healing by taking each individual tragedy, analyzing it, and making changes that helped the wider community. By making meaning out of IPH, advocates were able to honor the lives lost by acting on the lessons they had learned from them.

Unresolved Cases as a Barrier to Change

While overall advocates expressed that changing the approach to work helped them resolve distress and integrate IPH into their understanding, in the one IPH case that remained unsolved, distress continued to the present day. Gloria discussed one IPH over a decade earlier that remained open due to inadequate evidence, even though the victim had left a note naming their abuser as the perpetrator if they were killed. Gloria described this IPH as "a beginning that never ends," and this section of her interview is marked with the voice of trauma and an "I" that is often "angry." Because this case was not solved or identified as an IPH, it was never reviewed by the fatality review panel or considered by systems or agencies when modifying approaches in response to IPH. While Gloria could alter how she worked as individual in response to this IPH, the system did not change in ways relevant to this case despite her ongoing advocacy, leaving her with "enduring pissed-off rage." This negative case underlines the importance of allowing advocates to process IPH and adapt policy and procedure based on lessons learned, even in situations where cases are not resolved by the legal system.

Discussion

This study examined the effects of the IPH of a client on advocates' perception of and approach to their work. All the participants described changes due to vicarious trauma both in how they understood their work, and changes to their behaviors with future clients and with other service providers. The majority of the advocates had difficulty naming specific changes to their work due to IPH when asked directly, primarily due to their early experiences of IPH. Prior research with clinicians who work with refugees has indicated that early exposure to a client's trauma in one's career can shock their existing cognitive framework, shattering their worldview and requiring readjustment in the same way that repeated exposure to secondary trauma may affect one's cognitive schema over time (Barrington & Shakespeare-Finch, 2013). Other research of frontline practitioners has indicated that at any point in one's career, an acute incident (e.g., IPH) may necessitate practitioner adjustment (Gustavsson & MacEachron, 2002; Molnar et al., 2017). Notably, IPH seemed to function as an acute incident for the participants regardless of direct contact with the client prior to the incident, and more work is needed to better understand this indirect impact on practitioner functioning. These findings underline the importance of organizations acknowledging the potential transformative experience of IPH, especially early in one's career, by creating space for advocate processing through group or individual debriefing, peer support, and referrals to outside resources (Cohen & Collens, 2013; Gustavsson & MacEachron, 2002; Molnar et al., 2017).

The majority of participants described positive changes to their worldview, or vicarious resilience: changes to how they thought about their work and areas of growth from the loss. While past research has theorized that vicarious resilience requires exposure to the resilience of clients

themselves (Engstrom et al., 2008; Frey et al., 2017), this study, in line with past research on client suicide (Ting et al., 2006) and child maltreatment fatalities (Douglas, 2013a; Regehr et al., 2002), suggests that even when client resilience is disrupted by an event like IPH, an advocate can still experience vicarious resilience through changes in their worldview and how they practice.

A major change identified in the data was in whom participants perceived as clients, particularly through the mechanism of responsibility. Similar to findings in past research, even though advocates understood that the abuser was at fault for the IPH, they felt responsible due to their role in the community (Iliffe & Steed, 2000; Regehr et al., 2002). In studies of child maltreatment fatalities, findings suggest that a sense of shared responsibility also stemmed from an understanding of how easily the victim could have been on the worker's own caseload rather than their peer's (Regehr et al., 2002). This suggests that organizations should create opportunities for processing the traumatic event even when the client was not directly served by the agency and to all staff regardless of whether they served a client directly. For example, advocates could attend the trial of the perpetrator, or the staff could debrief the IPH. In addition, organizations should discuss feelings of responsibility during training and debriefings to normalize the reaction and give advocates tools to manage it (Cohen & Collens, 2013; Cummings et al., 2021; Molnar et al., 2017; Regehr et al., 2002; Ting et al., 2006). Findings from a national study on of child maltreatment fatalities, suggest that it is imperative that such conversations do not blame staff or focus on individuals, but rather validate emotional reactions and focus on changes to systems needed to improve future client outcomes (Douglas, 2013a).

The primary mechanism for promoting resiliency in which the advocates engaged was reflecting on what they had learned from the IPH and implementing changes to their work, agency protocol, and state policy. Prior studies on client loss in other sectors have also found that social worker adjustment was aided by "proactive" (Ting et al., 2006, p. 338) changes at the individual- and agency-level after the traumatic loss (Douglas, 2013a; Regehr et al., 2002). Studies in the general population have underlined the importance of applying lessons learned; it is not simply the search for meaning that is important, but the application of lessons gained from the experience (Linley & Joseph, 2011; Park, 2010). Notably, when advocates were unable to resolve their role in a case, as happened with Gloria, negative adjustment persisted. It is critical for organizations to create space for advocates to work through the crisis, either by enabling individual and agency reflection or by formally engaging in processes like fatality review panels (Cohen & Collens, 2013; Pack, 2014).

Advocates in the study gave several examples of internal changes, such as focusing on the support they could actualize with clients rather than "saving" [Isabella] them. Studies of other practitioners who work with traumatized populations have similarly underlined the importance of shifting the goal from salvation to accompaniment and of celebrating small victories (Ullman, 2010; Woolhouse et al., 2012). Specifically, among child welfare workers who experienced child death, workers who believed that the death was unavoidable reported less post-traumatic stress symptoms than those who did not (Douglas, 2013b). Thus, organizations should foster the development of a protective sense of advocacy as "in the living" [Marisa] both after the IPH and early in advocates' careers through training (Berger & Gelkopf, 2011; Cohen & Collens, 2013; Douglas, 2013b; Frey et al., 2017; Molnar et al., 2017).

Organizations should additionally support advocates in activities that could result in changes to agency protocol or state policy. Past research of vicarious traumatization and social worker experiences of client fatalities has suggested that being involved in political or community action activities could help lessen distress effects (Iliffe & Steed, 2000; Regehr et al., 2002; Ting et al., 2006). Organizations could create forums for staff to reflect on potential changes to agency protocol based on the lessons from IPH, such as the changes made in how the agency contacted clients described by Gloria. Past research suggests, however, that these changes cannot be superficial and meant only to appease (Regehr et al., 2002; Ting et al., 2006). Rather, these changes must be actionable and in response to worker concerns about and insights into agency protocol (Regehr et al., 2002; Ting et al., 2006).

Organizations should also encourage participation in multisector groups such as fatality review panels or high-risk teams. Past research has indicated that engagement in multisector groups helped decrease advocate isolation and increased feelings of efficacy (Johnson et al., 2014; Office for Victims of Crime, 2018). A study on the emotional impact of advocacy on sexual violence victim advocates determined that due to the role of advocates as system navigators, the majority of advocate distress was oriented at system inadequacies rather than individuals' behaviors (Wasco & Campbell, 2002). Therefore, engagement in system advocacy through multisector forums may be particularly helpful to advocates given their unique role. This study highlighted the importance of fatality review panels, even when advocates were not members, to create positive changes out of an IPH through implementing new policy.

Limitations

This study examined the specific impact of the IPH of a client on advocate's work. Even though qualitative methods are not intended to be generalizable, this study only sampled from half of the agencies in the state which could decrease the applicability of findings and implications locally (Braun & Clarke, 2006; Creswell, 2013). This study captured staff advocates' experiences of IPH directly and indirectly. More qualitative research is needed to understand how prior interaction with the IPH victim may affect the advocate differently than those who indirectly experienced the IPH, and if different responses are needed. Even indirect exposure affected advocates however, and future interventions should consider indirect exposure as a potential source of risk to workforce stability. Further, more research on how IPH affects the health of the continuum of IPH prevention services is needed to ensure continued workforce capacity. Volunteer advocates, who often staff hotlines, or advocates in the state coalition, who focus on system advocacy, may have different experiences with IPH due to differences in roles and/or supervision. Allied partners who work in close collaboration with advocates, like law enforcement officers, may also experience IPH differently than advocates. Despite the limitations of this study, it contributed to the extant literature by examining how IPH can affect advocates and offered some suggestions for intervention.

Conclusion

Advocacy agencies are critical providers of care to victims of IPV in the community. Advocates' work exposes them to the traumas of their clients, including potentially to IPH during their tenure. This study explored how the IPH of a client affected advocates' perception of and approach to their work. Findings suggested that IPH affected how advocates worked and resulted in changes to how they thought about their work, how they interacted with clients, and to agency protocol and state policy. Agencies have an opportunity to prevent vicarious traumatization and promote vicarious resilience through interventions before IPH, such as training, and after IPH, such as debriefings, in order to ensure the continued delivery of effective services to victims. It is imperative that organizations attend to secondary exposure to trauma in order to maintain agency effectiveness in the aftermath of IPH.

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